brings us these insights out of long years of the most painstaking, rigorous scientific research. He is one of the few people in the world who are using classical psychoanalytic methods in research —the prolonged, patient, free associative, intimate, detailed observation and documentation of internal human phenomena for the purposes of discovery.

To deal with a person who has this conviction that "he" is really a woman in a man's body, we must learn to empathize with this form of human behavior, and to do this effectively we have to be aware of our own hang-ups, our own psychosexual defenses. In a sense it involves getting in touch with the opposite sex that is in every one of us, and that can be pretty threatening. Essentially what these people are struggling with is a problem of identity—an overwhelming need to find an identity with which they can be comfortable, into which they can relax. And when we go in to try to help them we have to do it with a feather, gently. We are not public prosecutors—we don't enforce any law that says the way these people behave is illegal—we're physicians, and the first rule, always, is to do no harm!

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EDITORIAL COMMENT

Refer to: Fisk NM: Gender dysphoria syndrome: The conceptualization that liberalizes indications for total gender reorientation and implies a broadly based multi-dimensional rehabilitative regimen—Editorial comment on male transsexualism. West J Med 120:386-391, May 1974

Gender Dysphoria Syndrome—The Conceptualization that Liberalizes Indications for Total Gender Reorientation and Implies a Broadly Based Multi-Dimensional Rehabilitative Regimen

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RECENTLY THERE HAS BEEN an ever increasing interest or perhaps even a preoccupation in both the professional and lay sectors of the populace in a relatively small and select group of people who have been variously labeled or mislabeled as transsexuals. Professional interest is understandable based upon the fact that the complexities surrounding gender and all it implies are intriguing and challenging. Lay preoccupation, as demonstrated by a plethora of newspaper and magazine articles, television and radio talk shows, and books written for the laity by both professionals and patient alike, is superficially understandable given the exotic and often bizarre qualities implicit and explicit in this subject.[1-5] I would not discount a certain element of quasi-prurient interest or titillation that is understandable in professional and laymen alike.

Currently, it is most fadistic in certain intellectual and creative elite subgroups to demonstrate a fascination with cross-gender behavior and particularly in those who pursue this behavior. Beyond this, however, there likely dwells within us all a primal curiosity concerning the hows and whys of the particular gender orientation we embrace. Throughout recorded history as well as in multiple culturally determined legends and myths, there is ample evidence that cross-gender behavior has long been a fact of human existence.[6]

The term *transsexual* was coined by Dr. Harry

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Benjamin, an esteemed pioneer in the field of gender disorders.[7] Dr. Benjamin has written extensively about gender disorders and has had a vast and intensive clinical experience spanning many decades. The term (or diagnostic label) *transsexual* as applied to the male and female has seemingly served well to communicate salient differences existing between persons who have certain distinctive and aberrant emotional and behavioristic symptoms. As originally intended, the term *transsexual* was to specifically identify a person who was not to be confused with a homosexual or a transvestite. Many authorities on gender aberrations have considered it extremely significant to accurately define a differential diagnosis between the aforementioned conditions as well as all types of biologic intersex. While I would agree that the elucidation of biologic intersex is an essential prerequisite to the treatment of gender disorders, I feel rather strongly (given the experience of the Stanford University gender dysphoria program) that the differential diagnosis aimed at clearly identifying a subgroup of patients termed transsexuals is in many instances a rather non-productive effort. Beyond this, differential diagnosis does not significantly bear upon the success or failure of ensuing treatment.[8]

In a classical sense the male transsexual was a person who demonstrated lifelong behavior that was effeminate or imitative of the opposite sex, had a deep and abiding conviction that he was indeed a member of the female sex or gender, and that this non-psychotic conviction led him on an incessant search for medical and surgical transformation into the sex to which he felt he legitimately belonged. Further it was felt that transsexuals found their own genitalia repugnant or repulsive and also considered any interest (in his own genitalia) on the part of members of either the same or the opposite gender unpleasant. Such a person was often therefore described as rather asexual. Also it was strongly emphasized that the cross-dressing phenomenon should not and indeed must not carry with it any erotic connotation, as this would point directly toward the diagnosis of male transvestitism. As an addendum, I might add that many authorities felt the effeminate homosexual would very seldom pursue an intense search for surgical and medical gender reorientation, would derive reasonable sexual gratification from his own genitalia and if he would cross-dress at all in the fashion of "dragging" this would be done merely to enhance his attractiveness to other homosexuals. The medical literature stressed, in keeping with the revered concept of *primum non nocere,* that it was essential to clearly differentiate the classical transsexual from all other forms of gender deviation because if this were not done, gender reorientation with accompanying surgical sex conversion would not be the indicated treatment and could potentially prove to be harmful.

In 1968, armed with this knowledge and the insights gained by visiting various active gender reorientation programs throughout this country, staff members of Stanford University Medical Center embarked upon a clinical research project that ostensibly would answer the question of whether or not surgical sex conversion as part of gender reorientation was a beneficial means of treatment. Viewed in retrospect, this was a somewhat naive effort, for the research design did not provide a control group nor could it feasibly be expected to do so. More specifically, a decision was made to carefully screen applicants for surgical sex conversion and accept those who seemingly were good or ideal candidates and pursue what had heretofore been a rather arduous project of intensive and extensive long term follow-up. The fact that a matched control group not receiving surgical conversion would not exist obviously obscures the answer to the question regarding the benefit or lack thereof of surgical sex conversion. Our data, however, do allow us to answer an equally if not more pressing question and that is: Does surgical sex conversion harm a rather diverse group of patients who we feel are better identified as having gender dysphoria syndrome? The dictionary definition of gender as applied to its non-grammatical meaning, merely states *sex*. It is well known to students of biology and behavioral science that gender is a complex and convoluted compilation of a number of biological, psychological and psychosocial factors. Chromosomal make-up, sex of assignment and rearing, external and internal genital morphology, pre-natal and post-natal endocrinologic factors, as well as behavior, are all seemingly interrelated within the concept of the gender. A dictionary definition of dysphoria includes dissatisfaction, anxiety, restlessness and discomfort.[9]

Within the first two to three years of our investigation, it became apparent that when non-fabricated or, more precisely, honest and candid psy-

chobiographies were obtained from our patient population, there was indeed a great deal of diversity and deviance from what had been defined as the symptoms of "classical transsexualism." Moreover, the overtly present common denominator was the high level of dysphoria concerning the individual's gender of assignment or rearing. It became readily apparent that people presenting with gender problems actually made up a spectrum of gender disorders ranging from the mildest to the most severe forms of this affliction.

I readily agree that classical transsexualism as best described by Dr. Benjamin represents the most extreme form of gender dysphoria; and further, there is almost certainly operational within these persons a significant biologic, organic or somatic component to their problem. There are both ample and significant data available that in many sub-human species, gender behavior as well as gender determined endocrinologic function can be irrevocably changed by experimental manipulation of intrauterine and post-natal steroid sex hormones, particularly as related to the brain and hypothalamic areas.[10-15] There exists strongly suggestive evidence that in humans, too, hormonal aberrations bear a relationship to deviations of gender-associated behavior.[16,17] Recently, there have also appeared highly provocative reports of abnormalities in androgen metabolism in male homosexuals.[18-22]

In a quasi-humorous, but nevertheless, pertinent fashion, I can now easily formulate a conceptualization of gender disorders which would even include what could be termed in a Freudian paradigm "the psychopathology of everyday life," and that is that the mildest form of gender dysphoria might well be demonstrated by an apparently normal, well-adapted male who in all facets of his behavior, including his choice of sexual object, is overtly masculine. However, he chooses to participate for one to two weeks a year in his civic club's annual skit. His choice of participation is to cross-dress as a can-can girl or a member of a chorus line attired in female garb, and perform a dance routine. This is usually greeted by a fair degree of hilarity on the part of the viewing audience. I do not imply that this person has a form of behavior deviant enough or so significantly abnormal as to be so labeled or as to require treatment. I do wish to emphasize that not all men would derive pleasure or excitement or enjoyment from this particular type of activity; and, given that fact, I would once again reiterate that this would serve as an example of "psychopathology of everyday life" *vis à vis* gender dysphoria syndrome.

Encompassed in a spectrum of gender disorders would be effeminate homosexuality or hyper-masculine homosexuality in the female, male and female transvestitism, a fascinating subgroup of patients who could be termed inadequate passive-dependent personalities with a mild to moderate transvestic fetish and a group of overtly sociopathic persons who merely seek gender reorientation or sex conversion operations as a means of becoming a "professional" transsexual and thereby to gain fame, notoriety and wealth. Finally, many psychotic patients have a severe type of gender confusion. Twenty percent of all patients contacting our program are overtly psychotic and are of course referred for or given appropriate psychiatric treatment.

The concept of gender dysphoria syndrome grew out of clinical necessity very much in an organic, naturalistic fashion.[23] This occurred because virtually all patients who initially presented for screening provided us with a totally pat psychobiography which seemed almost to be well rehearsed or prepared, particularly in the salients pertaining to differential diagnoses. It would be accurate to say that of the initial 30 to 40 nonpsychotic patients screened, all presented as virtual textbook cases of classical transsexualism. Remembering the old medical saw that "the last time one sees a textbook case is when one closes the textbook," it was apparent that this group of patients were so intent upon obtaining sex conversion operations that they had availed themselves of the germane literature and had successfully prepared themselves to pass initial screening. In some instances they had rehearsed friends, spouses and family members in a similar fashion. Not all of them did this in a necessarily conscious, overt or sociopathic fashion. Many, in a subtly unconscious way, had retrospectively examined their life history and had amended certain key areas so that to themselves they did indeed represent the entity of classical transsexualism. I feel that many of these patients were in full flight from either effeminate homosexuality or transvestitism and were rushing to embrace the diagnosis of transsexualism for many valid reasons. Notwith-

standing our currently more liberal or permissive society, it is certainly much more acceptable and non-socially stigmatizing to have a legitimate medical illness than it is to suffer from a supposed moral perversion, sexual deviation or fetish. The pressures exerted by society at large as well as by various significant loved ones in the patient's life were sufficient in many instances to cause the patient to take on all the symptoms of classical transsexualism in order to obtain surgical sex conversion.

By employing the diagnostic term *gender dysphoria syndrome,* our indications for surgical sex conversion therapy have been broadened. Patients now clearly understand that had they been interviewed five or ten or twenty years ago, they would have been diagnosed as not being classical transsexuals. These patients are informed that a diagnosis of transsexualism is not in our view the only valid criterion for deciding who receives surgical sex conversion. Moreover, we practice the rather pragmatic dictum that nothing succeeds quite like success and therefore our criteria for surgical sex reassignment or conversion are more phenomenologically oriented. We are far more interested in the patient's status here and now and in the recent past, than we are in establishing a differential diagnosis. We avidly seek to determine how well or how badly a particular person has been coping and will cope with life in his gender of choice. Oftentimes patients have been living totally in their gender of choice along with the exogenous administration of the appropriate sex hormones for many years before they come to our facility. In the instances in which this is not true, then a mandatory period of trial cross-living on a 24 hours a day basis while receiving exogenous hormone treatment is requested for a minimum of 12 to 18 months, following which a thorough reevaluation is performed.

Factors such as physical passability, vocational skills, overall psychic and emotional stability, past and present ego strengths, familial support, appreciation of core gender principles, absence of significant sociopathy, absence of phychotic symptoms and multiple or intensive neurotic symptoms (as manifested by impulsivity, poor judgment, deviousness, narcissism, manipulativeness, masochism, exhibitionism and low self-esteem) are all factors that are heavily weighed in the overall team decision as to acceptability for sex conversion. Obviously, by liberalizing the indications for sex conversion through conceptualizing patients as having gender dysphoria, we also are committed to provide a program for patients encompassing many factors related to a total overall rehabilitative experience. These include vocational counseling and guidance, psychological and psychiatric supportive therapy, grooming clinics where role-appropriate behaviors are taught, explained and practiced, legal assistance, and, probably of most benefit, an opportunity is afforded to meet and interact with other patients who have successfully negotiated gender reorientation or who are in various phases of reorientation. This program employs some former patients as counselors to persons with gender disorders. Whenever possible, family members are included in the appropriate phase of gender reorientation.

To leave this subject without strongly emphasizing an all too often neglected point would be inexcusable. I refer specifically to the adequacy of the surgical sex conversion procedure itself. It is obviously an impossible task to evaluate the success or lack thereof of surgical sex conversion if the operation has not been performed in a manner that will allow the patient to function sexually with ease, enjoyment and assurance of a reasonable chance for success. All too often we see rather pathetic examples of patients who have acted impulsively or injudiciously and have sought surgical sex conversion by means which they consider to be most expedient. It is well known that this particular group of patients are extremely vulnerable to easy exploitation by charlatans and quacks. The tragic results are seen in persons who have had inadequate surgical operations and are not able to perform sexually either with ease or, in some instances, at all. These people represent a rather desperate and intensely frustrated and depressed group who require, where possible, expert surgical revision of procedures previously poorly done. Ofttimes the flagrant exploitation of these patients also includes participation in illicit markets for sex steroids, silicone injections and rather poorly performed ancillary surgical cosmetic procedures. It is for these reasons that it is critically important for reputable and responsible physicians to recognize the "medical legitimacy" of gender disorders and, where possible, to attempt either to successfully treat such patients or to refer them to those who can.

Unfortunately, both in the past and even now many physicians find it extremely difficult to separate their professional diagnostic and treatment skills from their own particular value system, which in some instances is highly tinged with moralism and judgmentalism. I have had the unpleasant experience of hearing a number of colleagues voice the opinion that gender reorientation with surgical sex conversion is an "immoral procedure" and in one particular instance have seen in print the statement that surgical sex conversion is "tantamount to medical malpractice." It is inconceivable to me how any valid attempt at the alleviation of human suffering and despair can be immoral. I certainly do not unequivocally believe that gender reorientation with surgical sex conversion will always remain the treatment of choice for persons with significant gender problems. However, it is rather well known and accepted that any mode of psychotherapy rather uniformly fails to alleviate symptoms. Therefore, in the present state of our knowledge there is seemingly ample evidence to indicate that gender reorientation with surgical sex conversion is a form of treatment that affords certain selected patients an opportunity to live a more joyful and fulfilling life.

The documentation of the feasibility or advisability of sex conversion is based upon our rather exhaustive five-year follow-ups that clearly indicate, in every instance of surgical sex conversion, that patients expressed the opinion that they were subjectively far happier than they had been before.[8] There exists additional evidence to further validate the point that for all groups (except for the gender dysphoria syndrome sub-diagnosis *transvestitism*) there was statistically significant improvement in social adjustment, psychologic adjustment, economic achievement and, for all groups, including transvestites, a highly significant improvement in sexual adjustment.[8] Lest this be viewed as a totally glowing report, I would add that our findings are congruent with other follow-up studies which indicate that gender reorientation does not significantly alter the fundamental characterologic structure of the individual patient. For this reason we more firmly than ever believe that the phenomenological selection of patients is far more appropriate than selection based upon differential diagnosis. Dr. Donald Laub, who heads the surgical team that performs the reconstructive operations, feels very strongly that the flexible, yet at once somewhat rigid, behavioristic requirements for acceptability into our program represent a very unique and distinctive form of behavioristic psychotherapy. Many patients who are initially denied surgical sex conversion are placed on a "hold" status to be re-evaluated again later. Implicit in this delay is the message that they should improve the overall stability of their life-style. For many patients this involves a waiting period of two to four years, and during this period pronounced changes in at least superficial behavior are observed. If one adheres to a doctrine of thought that believes a person eventually becomes what he or she seems to be, then Dr. Laub's supposition would indeed seem to be correct.

As a concluding thought, it should be stated that the surgical procedures involved for both males and females suffering from gender dysphoria syndrome are quite major and complex, and there is a significant rate of surgical complications. To date there have been no deaths reported in our series of 90 patients operated upon. Similarly, there have been no major psychiatric casualties in the form of psychotic decompensation, severe clinical depression or suicidal behavior. We are bringing to bear upon the problem of gender dysphoria the resources of a rather vast and well-equipped medical center, and this point must be strongly emphasized. In many instances these patients are very troubled persons who are extremely difficult to deal with; and the difficulties involve their families, loved ones and even their physicians, and they present challenging and oftentimes vexing problems. We would stress that physicians contemplating the thorough treatment of patients with gender dysphoria syndrome have in their armamentarium of therapies sufficient and significant ancillary and supportive paramedical facilities. These can be of immense help and can significantly ameliorate or prevent either patient or physician dissatisfaction and frustration.

There remain many unanswered questions concerning etiology, incidence, epidemiologic factors and treatment in regard to this most fascinating and troubled group of patients who all too often pose a problem that might be best expressed as "Help us, if you dare."

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